IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

April 23, 2002

Re: IRO Case # M2-02-0520-01

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Anesthesiology Pain Management. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The ___ reviewer who reviewed this case has determined that, based on the medical records provided, the requested care is not medically necessary. Therefore, ___ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

> This case involves a 35 year old male who was injured ___ when he fell off a ladder. He has experienced back and knee pain, and underwent knee surgery.
>
> I agree with the carrier's decision to deny the requested chronic pain management program. The psychological evaluation of the patient was cursory and did not include diagnostic instruments such as MMPI. The records present no evidence that this patient needs the full PMP with multiple modalities.
>
> The records suggest that more aggressive antidepresent therapy is indicated and more information is needed regarding the disposition of treatment for the HNP. The records provided did not indicate that the patient had had a surgical evaluation for the HNP.
>
> It would be appropriate to do a IMEIRME to evaluate the patient's status before embarking on behavioral modalities.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 4066, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

_____

President

I hereby certify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or US Postal Service from the office of the IRO on this _____ day of _____2002.

Signature of IRO Representative:

Printed name of IRO Representative: